

ATTACHMENT 6

Sample Prior Authorization Request Form (PA/RF) for chiropractic services

DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 11018 (Rev. 06/03)

STATE OF WISCONSIN
HFS 106.03(4), Wis. Admin. Code

WISCONSIN MEDICAID PRIOR AUTHORIZATION REQUEST FORM (PA/RF)

Providers may submit prior authorization (PA) requests by fax to Wisconsin Medicaid at (608) 221-8616; or, providers may send the completed form with attachments to: Wisconsin Medicaid, Prior Authorization, Suite 88, 6406 Bridge Rd, Madison, WI 53784-0088. **Instructions:** Type or print clearly. Before completing this form, read your service-specific PA/RF Completion Instructions.

FOR MEDICAID USE — ICN	AT	Prior Authorization Number 1234567
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SECTION I — PROVIDER INFORMATION

1. Name and Address — Billing Provider (Street, City, State, Zip Code) I.M. Provider 1 W. Williams Anytown, WI 55555	2. Telephone Number — Billing Provider (XXX) XXX-XXXX 4. Billing Provider's Medicaid Provider Number 87654321	3. Processing Type 118
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SECTION II — RECIPIENT INFORMATION

5. Recipient Medicaid ID Number 1234567890	6. Date of Birth — Recipient (MM/DD/YY) MM/DD/YY	7. Address — Recipient (Street, City, State, Zip Code) 1234 Street St. Anytown, WI 55555
8. Name — Recipient (Last, First, Middle Initial) Recipient, Ima A.		9. Sex — Recipient <input type="checkbox"/> M <input checked="" type="checkbox"/> F

SECTION III — DIAGNOSIS / TREATMENT INFORMATION

10. Diagnosis — Primary Code and Description 839.00 cervical vertebra, unspecified							11. Start Date — SOI	12. First Date of Treatment — SOI	
13. Diagnosis — Secondary Code and Description							14. Requested Start Date MM/DD/YY		
15. Performing Provider Number 87654321	16. Procedure Code 98940	17. Modifiers 1 2 3 4				18. POS 11	19. Description of Service Chiropractic manip/adjustments	20. QR 4.0	21. Charge XXX.XX

An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after the authorization expiration date. Reimbursement will be in accordance with Wisconsin Medicaid payment methodology and policy. If the recipient is enrolled in a Medicaid HMO at the time a prior authorized service is provided, Medicaid reimbursement will be allowed only if the service is not covered by the HMO.

23. SIGNATURE — Requesting Provider <i>I.M. Provider</i>	24. Date Signed MM/DD/YY
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FOR MEDICAID USE

Procedure(s) Authorized:

Quantity Authorized:

☐ Approved

Grant Date

Expiration Date

☐ Modified — Reason:

☐ Denied — Reason:

☐ Returned — Reason:

SIGNATURE — Consultant / Analyst

Date Signed